

1
 6769
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 06737

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro				c. LENGTH OF STAY IN 1b 1 Month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cherry Nursing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro			
				d. STREET ADDRESS None			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Moore				4. DATE OF DEATH Month 6 Day 13 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-12-1874	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 6 Days 13		IF UNDER 24 HRS. Hours 19 Min. 60			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Ohanlon				14. MOTHER'S MAIDEN NAME No Record			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT James L. Moore Greensboro, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 10 1959 to June 13 1960 that (I) (we) last saw the deceased alive on June 12 1960 , and that death occurred at 9A M, from the causes and on the date stated above.							
22a. SIGNATURE Charles H. Stonesifer				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Print) Charles H. Stonesifer, M.D.				22d. ADDRESS Greensboro, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-16-60		23c. NAME OF CEMETERY OR CREMATORY Greensboro		23d. LOCATION (City, town, or county) (State) Greensboro, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais				ADDRESS Greensboro, Md.		25a. REC'D BY REGISTRAR DATE JUN 17 '60	
				25b. REGISTRAR'S SIGNATURE Charles L. Hensel			

6768

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

1968

Caroline

Married

Caroline

Married

1 Month

Married One Month

Married One Month

None

None

None

62

11-1970

None

None

Joseph

None

None

None

None

None

None

None

None

None

None

None

None

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5764 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06732

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL DENTON</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RURAL DENTON</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>CLARK</u> Middle <u>CLARK</u> Last 4. DATE OF DEATH <u>JUNE</u> Month <u>11</u> Day <u>19</u> Year <u>60</u>				5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>SEPT 5, 1877</u> 9. AGE (In years last birthday) <u>82</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>home</u> 11. BIRTHPLACE (State or foreign country) <u>Delaware</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>John Tinley</u> 14. MOTHER'S MAIDEN NAME <u>Catherine Walker</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>not</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT (Address) <u>Howard Clark, Denton, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis, Acute</u> DUE TO (b) <u>Exhaustion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>few mins.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Dawson O. George</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>June 13, 1960</u>					
EXAMINER'S NAME (Type) <u>Dawson O. George M.D.</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 14, 1960</u> 22b. DATE THEREOF					
22c. NAME OF CEMETERY OR CREMATORY <u>Hollywood</u> 22d. LOCATION (City, town, or county) (State) <u>Harrington, Del.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Vergil Hoover</u> ADDRESS <u>Denton, Md.</u> 24a. REC'D BY REGISTRAR <u>JUN 16 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6765 CERTIFICATE OF DEATH

06733

1. PLACE OF DEATH o. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna.</u> b. COUNTY <u>Schleich</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Maryland</u>				c. LENGTH OF STAY IN 1b <u>4 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Orefield</u> <u>75X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HENRIETTA</u> First <u>HERRMANN</u> Middle <u>HERRMANN</u> Last				4. DATE OF DEATH Month <u>6</u> Day <u>1</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-26-1888</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Christian Wolfe</u>				14. MOTHER'S MAIDEN NAME <u>Margaretta Loeck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>John Herrmann Marydel, Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Cervix (infiltrative)</u> DUE TO <u>171X</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) _____ (c) _____ DUE TO _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 2</u> 19 <u>60</u> to <u>June 1</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>May 31</u> 19 <u>60</u> , and that death occurred at <u>2:30</u> A.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles H. Stonesifer</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/1/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer, M.D.</u>				22d. ADDRESS <u>Greensboro, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-4-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grandview</u>		23d. LOCATION (City, town, or county) (State) <u>Allentown Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Bouclair</u>				ADDRESS <u>Greensboro, Md.</u>		25a. REC'D BY REGISTRAR <u>June 2 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

RECEIVED
OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS

Office of the Director of the Bureau of the Census

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06734

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Federalsburg				c. LENGTH OF STAY IN 1b 53 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bridgeville Road				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frederick Middle William Last Hulliger				4. DATE OF DEATH Month June Day 6 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 15, 1892	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 67 Days 6 Hours 19 Min. 60		IF UNDER 24 HRS. Months 67 Days 6 Hours 19 Min. 60			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Bern, Switzerland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Hulliger				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW I		17. INFORMANT Mrs. Helen N. Hulliger		Address RFD Federalsburg	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Chronic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 yrs. 4 yrs.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dawson O. George				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Dawson O. George				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 9, 1960		22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son				ADDRESS Federalsburg		24a. REC'D BY REGISTRAR JUN 9 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6767

Item 9 Film G265 6-16-60 et

CERTIFICATE OF DEATH

06735

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg				c. LENGTH OF STAY IN 1b X Federalsburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 203 Denton Road				d. STREET ADDRESS 203 Denton Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Webster L Middle Jolley Last				4. DATE OF DEATH Month 6 Day 3 Year 19 60			
5. SEX Male		6. COLOR OR RACE AA		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-12-1902	
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY Educational		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Edward Jolley				14. MOTHER'S MAIDEN NAME Lillie Adams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N. (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-14-3394			
17. INFORMANT Mrs. Margaret Jolley, Federalsburg, Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of the Liver DUE TO 581-0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from May 10 , 19 58 , to June 3 , 19 60 , that I last saw the deceased alive on June 3 , 19 60 , and that death occurred at 8:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Metzger, Jr.				ADDRESS (Street, city or town, state) DATE SIGNED Main Market Sts, 6/6/60			
PHYSICIAN'S NAME (Type) G. Metzger, Jr. M.D.				ADDRESS Bridgetown, Delaware			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/7/60		22c. NAME OF CEMETERY OR CREMATORY Petersburg Cem -		22d. LOCATION (City, town, or county) (State) Petersburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley, Salisbury, Md				24a. REC'D BY REGISTRAR DATE JUN 13 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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6768
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06738

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Marydel		c. LENGTH OF STAY IN 1b 40 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Michele First LePore Middle LePore Last		4. DATE OF DEATH 6 Month 18 Day 19 Year 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-1876
9. AGE (In years lost birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy ✓	
13. FATHER'S NAME Joseph LePore		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Felice LePore Marydel, Maryland Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Cardiovascular/Disease 442 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) General Arteriosclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1 19 58 to June 18 19 60 , that (I) (we) last saw the deceased alive on June 18 19 60 , and that death occurred at 5AM , from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Stonesifer M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.		22d. ADDRESS Greensboro, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-22-60	
23c. NAME OF CEMETERY OR CREMATORY Holy Cross		23d. LOCATION (City, town, or county) (State) Dover, Delaware	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaie ADDRESS Greensboro, Md.		25a. REC'D BY REGISTRAR JUN 22 '60 DATE	
		25b. REGISTRAR'S SIGNATURE Charles H. Stonesifer	

(M)

(1)

Black & White

6-22-60

Black & White

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6763

CERTIFICATE OF DEATH

Reg. Dist. No.

06738

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>				c. LENGTH OF STAY IN 1b <u>40 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SALLIE ANN MORGAN</u>				4. DATE OF DEATH Month Day Year <u>JUNE 25 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 10, 1873</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Henry Bullock</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca C. Piden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT Address <u>Wm. Talmage Strong Denton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 mos. 6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 19 <u>60</u> , to <u>June 23</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 23</u> , 19 <u>60</u> , and that death occurred at <u>6:35 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Dawson D. George M.D.</u> <u>June 28, 1960</u>							
ACTUAL SIGNATURE <u>Dawson D. George</u>							
PHYSICIAN'S NAME (Type) <u>Dawson D. George M.D.</u> <u>Denton, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>June 28, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Garth Hoover Denton Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinas</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06739

6770

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		c. LENGTH OF STAY IN 1b 3 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Charles Street				d. STREET ADDRESS same		
3. NAME OF DECEASED (Type or print) Paul E. Nichols			4. DATE OF DEATH June 27, 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		
8. DATE OF BIRTH Jan. 21, 1906		9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer and plant wrap co. employee			10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John W. Nichols			
14. MOTHER'S MAIDEN NAME Cecelia Collins			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 213-22-6215			17. INFORMANT Mrs. Chas Klein			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock - Hemorrhage DUE TO (b) Gun shot wound to face Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) Self Inflicted			INTERVAL BETWEEN ONSET AND DEATH sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Asphyxiation						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gun shot wound to face				
20c. TIME OF INJURY Month, Day, Year June 27, 1960		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		
20f. (City or town) Federalsburg		(County) Caroline		(State) Md.		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Dawson D. George			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dawson D. George M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED June 29, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF June 30, 1960		22c. NAME OF CEMETERY OR CREMATORY Concord Cemetery		
22d. LOCATION (City, town, or county) rural Federalsburg		(State) Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Harvey Williams			ADDRESS Federalsburg, Md.			
24a. REC'D BY REGISTRAR MIL 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
6771
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6771
CERTIFICATE OF DEATH

06740

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely		c. LENGTH OF STAY IN 1b 74 yr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Edward Last Ross		4. DATE OF DEATH Month June Day 26 Year 1960	
5. SEX Male	6. COLOR OR RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1885
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min. 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cannery Worker		10b. KIND OF BUSINESS OR INDUSTRY Cannery	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Ross		14. MOTHER'S MAIDEN NAME Sarah Pippen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-05-8287A	
17. INFORMANT Mrs. Katie Ross		Address Ridgely, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 10, 1959 to June 26, 1960 , that (I) (we) lost saw the deceased alive on June 26, 1960 , and that death occurred at June 26, 1960 M, from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Stonesifer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.		22d. ADDRESS Greensboro, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-30-60	
23c. NAME OF CEMETERY OR CREMATORY Ridgely		23d. LOCATION (City, town, or county) (State) Ridgely, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaie Greensboro, Md.		25. REC'D BY REGISTRAR DATE JUN 29 '60	
25a. REGISTRAR'S SIGNATURE Arthur S. Kline		25b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

1771

1771

Caroline

Caroline

Caroline

Caroline

Caroline

Caroline

Caroline

June

June

June

June

Nov. 11, 1932

Nov. 11, 1932

Delaware

Delaware

Delaware

Charles Jones

Charles Jones

Charles Jones

Charles Jones

Charles Jones

Charles Jones

Johnston, Johnston

Johnston, Johnston

Johnston, Johnston

June 22, 1932

June 22, 1932

June 22, 1932

Johnston, Johnston

Johnston, Johnston

Johnston, Johnston

Johnston, Johnston

Johnston, Johnston

Johnston, Johnston

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6772

CERTIFICATE OF DEATH

Reg. Dist. No.

06741

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - Rural				c. LENGTH OF STAY IN 1b 47 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Hynson				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Adolph Middle Reinhardt Last Seaman				4. DATE OF DEATH Month June Day 21 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1909	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Ridgeway, North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Seaman				14. MOTHER'S MAIDEN NAME Mary Ischer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-36-1759		INFORMANT Address Mrs. Marie J. Seaman, Preston, Maryland, RFD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Embolus 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Moderate Arteriosclerosis DUE TO (c) Mild Hypertensive Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH ? minutes 10 yrs. 10 yrs.						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Moderately Severe Diabetes Mellitus - ? 6 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/14 , 19 57 to 6/21 , 19 60 ; that I last saw the deceased alive on 6/14/1960 , and that death occurred at 6:40 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Harley B. Plummer M.D.				ADDRESS Preston Md. DATE SIGNED			
PHYSICIAN'S NAME (Type) Dr. H. B. Plummer				ADDRESS Preston Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 25, 1960		22c. NAME OF CEMETERY OR CREMATORY Junior Order Cemetery		22d. LOCATION (City, town, or county) (State) Linchester, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE JUN 28 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

6772

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - NEW YORK

10-1-1911

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06742**

6773

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - Rural			c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - Rural			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Harmony				d. STREET ADDRESS Near Harmony			
3. NAME OF DECEASED (Type or print) First Emerson Middle Pennewell Last Willis				4. DATE OF DEATH Month June Day 18 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1896		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Penn Willis				14. MOTHER'S MAIDEN NAME Nellie Gullette			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. M. Martha Layton, Preston, Md., R.F.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Causes of Reaction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 2 yrs -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF June 21, 1960		22c. NAME OF CEMETERY OR CREMATORY Concord Cemetery	
22d. LOCATION (City, town, or county) (State) Near Federalsburg, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE JUN 22 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING 10

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED _____		2. SEX _____		3. AGE _____	
4. DATE OF DEATH _____		5. TIME OF DEATH _____		6. PLACE OF DEATH _____	
7. CITY OR TOWN _____		8. COUNTY _____		9. STATE _____	
10. OCCUPATION _____		11. CAUSE OF DEATH _____		12. MANNER OF DEATH _____	
13. SIGNATURE OF MEDICAL EXAMINER _____		14. SIGNATURE OF DECEASED _____		15. SIGNATURE OF WITNESS _____	
16. DATE OF EXAMINATION _____		17. TIME OF EXAMINATION _____		18. PLACE OF EXAMINATION _____	
19. CITY OR TOWN _____		20. COUNTY _____		21. STATE _____	
22. OCCUPATION _____		23. CAUSE OF DEATH _____		24. MANNER OF DEATH _____	
25. SIGNATURE OF MEDICAL EXAMINER _____		26. SIGNATURE OF DECEASED _____		27. SIGNATURE OF WITNESS _____	
28. DATE OF EXAMINATION _____		29. TIME OF EXAMINATION _____		30. PLACE OF EXAMINATION _____	
31. CITY OR TOWN _____		32. COUNTY _____		33. STATE _____	
34. OCCUPATION _____		35. CAUSE OF DEATH _____		36. MANNER OF DEATH _____	
37. SIGNATURE OF MEDICAL EXAMINER _____		38. SIGNATURE OF DECEASED _____		39. SIGNATURE OF WITNESS _____	
40. DATE OF EXAMINATION _____		41. TIME OF EXAMINATION _____		42. PLACE OF EXAMINATION _____	
43. CITY OR TOWN _____		44. COUNTY _____		45. STATE _____	
46. OCCUPATION _____		47. CAUSE OF DEATH _____		48. MANNER OF DEATH _____	
49. SIGNATURE OF MEDICAL EXAMINER _____		50. SIGNATURE OF DECEASED _____		51. SIGNATURE OF WITNESS _____	
52. DATE OF EXAMINATION _____		53. TIME OF EXAMINATION _____		54. PLACE OF EXAMINATION _____	
55. CITY OR TOWN _____		56. COUNTY _____		57. STATE _____	
58. OCCUPATION _____		59. CAUSE OF DEATH _____		60. MANNER OF DEATH _____	
61. SIGNATURE OF MEDICAL EXAMINER _____		62. SIGNATURE OF DECEASED _____		63. SIGNATURE OF WITNESS _____	
64. DATE OF EXAMINATION _____		65. TIME OF EXAMINATION _____		66. PLACE OF EXAMINATION _____	
67. CITY OR TOWN _____		68. COUNTY _____		69. STATE _____	
70. OCCUPATION _____		71. CAUSE OF DEATH _____		72. MANNER OF DEATH _____	
73. SIGNATURE OF MEDICAL EXAMINER _____		74. SIGNATURE OF DECEASED _____		75. SIGNATURE OF WITNESS _____	
76. DATE OF EXAMINATION _____		77. TIME OF EXAMINATION _____		78. PLACE OF EXAMINATION _____	
79. CITY OR TOWN _____		80. COUNTY _____		81. STATE _____	
82. OCCUPATION _____		83. CAUSE OF DEATH _____		84. MANNER OF DEATH _____	
85. SIGNATURE OF MEDICAL EXAMINER _____		86. SIGNATURE OF DECEASED _____		87. SIGNATURE OF WITNESS _____	
88. DATE OF EXAMINATION _____		89. TIME OF EXAMINATION _____		90. PLACE OF EXAMINATION _____	
91. CITY OR TOWN _____		92. COUNTY _____		93. STATE _____	
94. OCCUPATION _____		95. CAUSE OF DEATH _____		96. MANNER OF DEATH _____	
97. SIGNATURE OF MEDICAL EXAMINER _____		98. SIGNATURE OF DECEASED _____		99. SIGNATURE OF WITNESS _____	
100. DATE OF EXAMINATION _____		101. TIME OF EXAMINATION _____		102. PLACE OF EXAMINATION _____	
103. CITY OR TOWN _____		104. COUNTY _____		105. STATE _____	
106. OCCUPATION _____		107. CAUSE OF DEATH _____		108. MANNER OF DEATH _____	
109. SIGNATURE OF MEDICAL EXAMINER _____		110. SIGNATURE OF DECEASED _____		111. SIGNATURE OF WITNESS _____	
112. DATE OF EXAMINATION _____		113. TIME OF EXAMINATION _____		114. PLACE OF EXAMINATION _____	
115. CITY OR TOWN _____		116. COUNTY _____		117. STATE _____	
118. OCCUPATION _____		119. CAUSE OF DEATH _____		120. MANNER OF DEATH _____	
121. SIGNATURE OF MEDICAL EXAMINER _____		122. SIGNATURE OF DECEASED _____		123. SIGNATURE OF WITNESS _____	
124. DATE OF EXAMINATION _____		125. TIME OF EXAMINATION _____		126. PLACE OF EXAMINATION _____	
127. CITY OR TOWN _____		128. COUNTY _____		129. STATE _____	
130. OCCUPATION _____		131. CAUSE OF DEATH _____		132. MANNER OF DEATH _____	
133. SIGNATURE OF MEDICAL EXAMINER _____		134. SIGNATURE OF DECEASED _____		135. SIGNATURE OF WITNESS _____	
136. DATE OF EXAMINATION _____		137. TIME OF EXAMINATION _____		138. PLACE OF EXAMINATION _____	
139. CITY OR TOWN _____		140. COUNTY _____		141. STATE _____	
142. OCCUPATION _____		143. CAUSE OF DEATH _____		144. MANNER OF DEATH _____	
145. SIGNATURE OF MEDICAL EXAMINER _____		146. SIGNATURE OF DECEASED _____		147. SIGNATURE OF WITNESS _____	
148. DATE OF EXAMINATION _____		149. TIME OF EXAMINATION _____		150. PLACE OF EXAMINATION _____	
151. CITY OR TOWN _____		152. COUNTY _____		153. STATE _____	
154. OCCUPATION _____		155. CAUSE OF DEATH _____		156. MANNER OF DEATH _____	
157. SIGNATURE OF MEDICAL EXAMINER _____		158. SIGNATURE OF DECEASED _____		159. SIGNATURE OF WITNESS _____	
160. DATE OF EXAMINATION _____		161. TIME OF EXAMINATION _____		162. PLACE OF EXAMINATION _____	
163. CITY OR TOWN _____		164. COUNTY _____		165. STATE _____	
166. OCCUPATION _____		167. CAUSE OF DEATH _____		168. MANNER OF DEATH _____	
169. SIGNATURE OF MEDICAL EXAMINER _____		170. SIGNATURE OF DECEASED _____		171. SIGNATURE OF WITNESS _____	
172. DATE OF EXAMINATION _____		173. TIME OF EXAMINATION _____		174. PLACE OF EXAMINATION _____	
175. CITY OR TOWN _____		176. COUNTY _____		177. STATE _____	
178. OCCUPATION _____		179. CAUSE OF DEATH _____		180. MANNER OF DEATH _____	
181. SIGNATURE OF MEDICAL EXAMINER _____		182. SIGNATURE OF DECEASED _____		183. SIGNATURE OF WITNESS _____	
184. DATE OF EXAMINATION _____		185. TIME OF EXAMINATION _____		186. PLACE OF EXAMINATION _____	
187. CITY OR TOWN _____		188. COUNTY _____		189. STATE _____	
190. OCCUPATION _____		191. CAUSE OF DEATH _____		192. MANNER OF DEATH _____	
193. SIGNATURE OF MEDICAL EXAMINER _____		194. SIGNATURE OF DECEASED _____		195. SIGNATURE OF WITNESS _____	
196. DATE OF EXAMINATION _____		197. TIME OF EXAMINATION _____		198. PLACE OF EXAMINATION _____	
199. CITY OR TOWN _____		200. COUNTY _____		201. STATE _____	
202. OCCUPATION _____		203. CAUSE OF DEATH _____		204. MANNER OF DEATH _____	
205. SIGNATURE OF MEDICAL EXAMINER _____		206. SIGNATURE OF DECEASED _____		207. SIGNATURE OF WITNESS _____	
208. DATE OF EXAMINATION _____		209. TIME OF EXAMINATION _____		210. PLACE OF EXAMINATION _____	
211. CITY OR TOWN _____		212. COUNTY _____		213. STATE _____	
214. OCCUPATION _____		215. CAUSE OF DEATH _____		216. MANNER OF DEATH _____	
217. SIGNATURE OF MEDICAL EXAMINER _____		218. SIGNATURE OF DECEASED _____		219. SIGNATURE OF WITNESS _____	
220. DATE OF EXAMINATION _____		221. TIME OF EXAMINATION _____		222. PLACE OF EXAMINATION _____	
223. CITY OR TOWN _____		224. COUNTY _____		225. STATE _____	
226. OCCUPATION _____		227. CAUSE OF DEATH _____		228. MANNER OF DEATH _____	
229. SIGNATURE OF MEDICAL EXAMINER _____		230. SIGNATURE OF DECEASED _____		231. SIGNATURE OF WITNESS _____	
232. DATE OF EXAMINATION _____		233. TIME OF EXAMINATION _____		234. PLACE OF EXAMINATION _____	
235. CITY OR TOWN _____		236. COUNTY _____		237. STATE _____	
238. OCCUPATION _____		239. CAUSE OF DEATH _____		240. MANNER OF DEATH _____	
241. SIGNATURE OF MEDICAL EXAMINER _____		242. SIGNATURE OF DECEASED _____		243. SIGNATURE OF WITNESS _____	
244. DATE OF EXAMINATION _____		245. TIME OF EXAMINATION _____		246. PLACE OF EXAMINATION _____	
247. CITY OR TOWN _____		248. COUNTY _____		249. STATE _____	
250. OCCUPATION _____		251. CAUSE OF DEATH _____		252. MANNER OF DEATH _____	
253. SIGNATURE OF MEDICAL EXAMINER _____		254. SIGNATURE OF DECEASED _____		255. SIGNATURE OF WITNESS _____	
256. DATE OF EXAMINATION _____		257. TIME OF EXAMINATION _____		258. PLACE OF EXAMINATION _____	
259. CITY OR TOWN _____		260. COUNTY _____		261. STATE _____	
262. OCCUPATION _____		263. CAUSE OF DEATH _____		264. MANNER OF DEATH _____	
265. SIGNATURE OF MEDICAL EXAMINER _____		266. SIGNATURE OF DECEASED _____		267. SIGNATURE OF WITNESS _____	
268. DATE OF EXAMINATION _____		269. TIME OF EXAMINATION _____		270. PLACE OF EXAMINATION _____	
271. CITY OR TOWN _____		272. COUNTY _____		273. STATE _____	
274. OCCUPATION _____		275. CAUSE OF DEATH _____		276. MANNER OF DEATH _____	
277. SIGNATURE OF MEDICAL EXAMINER _____		278. SIGNATURE OF DECEASED _____		279. SIGNATURE OF WITNESS _____	
280. DATE OF EXAMINATION _____		281. TIME OF EXAMINATION _____			